POVERTY AND HEALTH

REGIONAL ISSUES: SOUTH-EAST ASIA

World Health Organization
Regional Office for South-East Asia
New Delhi
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This monograph on poverty and health has been developed by the Marga Institute, Sri Lanka Centre for Development Studies, Colombo, Sri Lanka. The original draft was reviewed by an international expert panel, convened by the South East Asia Regional Office of the World Health Organization, New Delhi, India, in 1997. The expert panel furthermore developed the front-line messages on poverty and health at the beginning of this publication.

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Front-line Messages

POVERTY HAS many faces and, indeed, many roots. Poverty is about low levels of income, food deprivation, poor education, and ill-health. Poverty is about the underprivileged and the marginalized. No matter how poverty is defined and how the poverty line is drawn, countries of the South-East Asia Region have a very high concentration of aggregate mass poverty. This can be seen on two counts. First, using the "dollar a day" yardstick, one finds that the Region has an extremely high incidence of poverty in terms of headcount index. Second, the total number of absolute poor living in the Region represents the largest segment of poverty in the world. The sheer burden of poverty in the Region is something that needs to be recognized urgently while formulating any development policy and programme, be it in the area of macroeconomics, infrastructure, or health. There is variation, however, in the poverty levels among the countries of the Region, ranging from very high-poverty countries (such as Nepal and Bangladesh) to relatively low poverty countries (such as Thailand and Indonesia). However, even in countries with better economic indicators, there are substantial numbers of people living in poverty.

The poor are not homogeneous. This can be seen through the prism of every single indicator irrespective of whether it concerns income, calorie intake, housing, clothing, education, health or crisis-coping capacity. As per the income measure, the extremely poor constitute roughly about half of the total poor population. The gap between the poor and the poorest as well as the existence of a large number of underclass extremely poor beyond the pale of moderate poverty (and normal market processes) is something which policy-makers must come to terms with, while designing health or poverty interventions. The aspect of heterogeneity among the poor is particularly revealing when gender differentials are

taken into consideration. Women and girls in poor households are in fact the worst affected in all respects: poverty, literacy, vulnerability and welfare.

The pro-poor concerns emerge at the top of the policy agenda primarily because of considerations of social justice, equity or re-distributive compulsions. Such concerns are justified even on grounds of economic growth and social development. Thus, one of the key empirical results of the cross-country growth literature is that countries with a favourable initial income distribution (i.e. lower income inequality measure) also experience higher subsequent economic growth, as for instance, countries of East Asia. This is not to suggest that economic growth does not influence poverty alleviation. Growth is an essential factor, but a pro-poor distribution of growth through investment in health and education will help to achieve still higher growth rates. The concern for pro-poor distributive policies, however, need not distort the incentives for growth itself. Second, the countries which reduced poverty at a faster rate are also the countries which have achieved higher levels of social indicators (infant mortality, literacy, life expectancy at birth, etc.) more speedily.

Given the multidimensional nature of poverty, it is clear that all routes taken for poverty alleviation matter. Poverty can be eradicated only by attacking it on all fronts. It is in this context that the interface between poverty and health assumes critical significance. Several aspects of the health-poverty interface are notable. First, ill-health imposes a significant economic burden on the poor. Private health expenses consume about 10-15 per cent of the extremely poors' income. If this burden can be relieved through greater targeting and provision of public and community health care, it will have a substantial poverty-reducing effect. Another important aspect of the interface lies in the acute vulnerability of poor households to sudden and unanticipated health-related shocks. This leads to the loss of income and employment. A related point is the way poor households cope with such health crises. In most cases, the poor rely on their meagre savings for meeting the medical costs. In contrast, borrowing from the informal credit market is observed in only a few cases, implying a limited role of the latter in providing for

health related risk insurance for the poor. However, even in cases where borrowing is resorted to, the poor can easily be caught in a debt trap. The almost exclusive reliance on savings reduces the long-term accumulation of assets. Ill-health thus pushes the poor deeper into poverty. It reduces their growth capacity and diminishes further the likelihood of their getting out of the poverty trap. The dynamic effects of ill-health are also important in explaining the vulnerability of the poor of tomorrow. Many currently non-poor households just above the poverty line may slip into poverty because of health-related risks. In sum, the poor invariably bear a very disproportionate burden of diseases and ill-health, particularly infectious diseases including HIV/AIDS. For this reason, investing in health and nutrition benefits all: most of all the poor.

The lessons are clear: poverty cannot be eradicated without simultaneous action on the health front. Provision of adequate health care is a necessary precondition for faster reduction of poverty and higher economic growth. This is not just because of the positive synergistic effects associated with acting simultaneously on both the income and human development fronts, as evidenced from the review of the macro performance of the countries in the Region. This is also a direct result of the income erosion problem arising out of health-related risks and vulnerabilities, which have adverse long-term implications for poverty reduction.

The centrality of health in development efforts is also manifested in other ways. Economic gains are often wiped out, or reduced considerably, by the adverse effects of ill health. Even in the case of such successful micro examples of income generation as targeted microcredit programmes, the net impact of credit and other growth elements is often eroded by the lack of an adequate insurance mechanism against health-related risks. Another example are negative health effects (externalities) often caused by the various sectoral policies currently being pursued as "development". Many of the rapidly growing, export-oriented industries, for instance, have workers who suffer from occupational diseases. There is considerable scope to reexamine and refashion such sectoral policies for growth. The purpose is to have a "win-win" situation, i.e., have both growth and improved health status at the same time. Active use of the media towards avoiding the pitfalls of

indiscriminate policies of "modernisation" would curb the negative health influences and promote health.

Successful health interventions, in the context of poverty alleviation, cannot be implemented without a minimum of four conditions. First, a pro-poor restructuring of budgetary allocations for the health sector is needed. This is not just an issue of quantity allocations, but also (and more importantly) one of ensuring quality. Secondly, increased allocations for the health sector must be targeted to the needs of the poor in both rural and urban areas with particular attention being paid to the gender dimension and disparities. Thirdly, the success of both anti-poverty and health interventions cannot be achieved without effective participation of all sections of the community, particularly the poor, in the spirit of solidarity and social cohesion. The community needs to be involved in designing, implementing and monitoring the policies and programmes. Fourthly, as access to public health facilities is dismally low for the poor, and utilization of public health facilities is also very low, a judicious mix of health providers with increased involvement of NGOs and the local community is warranted. High absenteeism among doctors and inadequate attention to client satisfaction are some of the pressing problems facing the public health delivery system. Also, within the milieu of poverty, the full potential of self-care at the community and family levels should be explored.

The pro-poor interventions must maintain an adequate gender focus, with particular sensitivity to the health care needs of poor women. Women carry a disproportionate burden of poverty, illiteracy, malnutrition and ill-health. Little wonder that the vast majority of women in the Region suffer from anaemia. Maternal mortality is unacceptably high in virtually all countries of the Region. A pressing need is to start interventions such as nutrition and education for the girl child and women. This is also because investing in women has strong synergistic effects on other dimensions of welfare and productivity: lower fertility, consumption of food of higher quality, greater expenditure on (and improved nutritional status of) children, and better use of household resources (etc). It needs to be recalled that Jawaharlal Nehru, architect of modern India and the country's first Prime Minister, observed: "To

awaken people, it is the women who must be awakened. Once she is on the move, the family moves, the village moves, the nation moves".

In order to sustain the health interventions, it must be ensured they are efficient as well. However, in moving towards a more market sensitive health care system, the concerns of the poor must be protected. In particular, the current health sector reform and restructuring initiatives must ensure that the poorest are not marginalized in the process.

Meeting the needs of the poor is not easy, particularly when it comes to curative health. Difficulties arise from problems of identifying the poor through easy-to-capture indicators, leakages to the non-poor, low levels of empowerment which prevent the poor from being active on the health front and an entrenched health bureaucracy (etc). While each country must develop its specific targeting instruments, a convenient way is to target poor areas defined either by income or poverty criteria and/or by vulnerability to disaster, to ecological change, or to environmental degradation. It is also useful to target on the basis of ethnicity, caste and other "cultural" characteristics which are strongly associated with high incidence of poverty and deprivation. Fortunately, primary health care activities such as immunization, food and nutrition, family planning services and reproductive health programmes are, by their very nature and design, generally broad-based and cover particularly the poor and vulnerable.

INTRODUCTION

THIS MONOGRAPH examines the situation relating to health and poverty in the 10 countries comprising WHO's South-East Asia Region (SEAR, i.e. Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand). The main focus of this monograph is the relationship between poverty and health. The 10 countries of the Region span a per capita income range from US $ 190 for Nepal to US$ 2,110 for Thailand (1993). While the majority of the countries are in the low income group as defined in the World Bank's World Development Report, four countries are in the lower middle income category. The Region as a whole contains the largest concentration of absolute poverty in the world. Variations in health indicators among the countries are notable. The gradation of incomes of these countries and the accompanying changes in the health status are useful for identifying and analysing the nature and significance of the links that exist between poverty and health.

The major challenge facing policy-makers is to improve the health status of the population in the conditions of poverty prevailing in a large part of this Region.

The link between health and poverty is two-fold. Poor health retains the poor in poverty and poverty retains them in poor health. A strategy of poverty alleviation has to direct special efforts at severing this link to take people out of the trap of ill-health and poverty. Similarly, the link between health and economic development is two-fold. While economic development generally leads to improved health, investing in health contributes to economic growth in many ways. For instance, it reduces

production losses caused by worker illness, and thus raises productivity. It permits the use of natural resources that had been inaccessible because of disease. Importantly, it increases the enrolment of children in school and enhances their learning ability. It frees time for alternative uses which would otherwise have to be spent on treating illness. Most significantly, the gains of investment in health are relatively greater for poor people. The poor, especially the female poor, are typically most handicapped by ill-health. They stand to gain most from development of underutilized natural resources. Thus investment in health contributes to poverty alleviation. To elaborate: the adverse effects of ill-health are greatest for poor people, mainly because they are ill more often, and partly because their income depends exclusively on physical labour and they have no savings to cushion the blow of ill-health. They, therefore, find it impossible to recover from illness with their human and financial capital intact. The health consequences of poverty are severe: the poor die younger and suffer more from disability. They are exposed to greater health risks, both at home and at work, from unhealthy and dangerous conditions. Malnutrition and the legacy of past illnesses mean that the poor are more likely to fall ill and slower to recover, especially if they do not have access to affordable health care. Health and economic development, and health and poverty, have therefore a two-way relationship. The bottom line is that good health is a fundamental goal of development as well as a means of accelerating it.

Low income is often identified as the principal characteristic of poverty with other forms of deprivation as its derivatives. This often tends to intensify the processes that lead to and perpetuate poverty. Poverty, when broadly defined as the lack of resources to satisfy basic needs, is multidimensional in character. It is a condition which encompasses deprivation in a variety of forms:

- inadequate *income*,
- lack of *education*, knowledge and skill,
- poor *health* status and lack of access to health care,

- poor *housing,*
- lack of access to *safe water and sanitation*
- insufficient *food and nutrition,*
- lack of control over the *reproductive process.*

While most often these exist together, deprivation in any one form acts separately and independently as a determinant of poverty reinforcing the other factors. The overall condition of deprivation is therefore perpetuated. This is especially true of deprivation in health. *Health status is linked to all other variables. It is, therefore, necessary to identify strategies in which health improvements are coordinated with improvements in other socioeconomic and health-related conditions which continuously interact and reinforce each other.*

This monograph follows the conceptual approach outlined above in exploring the links between health and poverty in the countries of the South-East Asia Region of the World Health Organization. There are five parts. The first part presents the data on the main socioeconomic variables relating to health and poverty in the countries of the Region and analyses the main trends in the last quarter of a century. The second part discusses the macro-economic context and the framework of development strategies and policies of the past two decades and relates these to social outcomes. This part includes a discussion of recent policies of structural adjustment and their impact on poverty and health. The third part examines the issues relating to the links between health and poverty as they arise from the analysis in the preceding parts. It presents a set of broad conclusions regarding the typical problems and policy issues concerning health and poverty. The fourth part summarises the nature of responses needed at the macro-level to strengthen the link between poverty alleviation and health, drawing on the relevant experience of the countries. The fifth part describes and analyses some of the micro level interventions in the field of

poverty alleviation and the partnerships that have grown between government authorities, NGOs and private business.

SOCIAL INDICATORS FOR THE REGION

THE TABLES 1.1-1.5 at Annex A present a set of selected social indicators which reflect the state of health and human capital development in the Region. The data are given for three points of time for the last two and a half decades-1970, 1980, 1993 or the latest year for which data are available after 1990. The data therefore provide an overview of the broad trends during the last 25 years. The Region has, at one end, countries which fall into the least developed category (Nepal, Bangladesh, Bhutan) and at the other, fast growing countries in the lower middle income range (Indonesia, Thailand). Owing to the paucity of available data only a few indicators are provided for the Democratic People's Republic of Korea. The data for India are given at the aggregated national level. It should be noted that such aggregate data do not uncover the vast socioeconomic diversity and variations within India, a country and population of sub-continental proportions.

Regional Trends

When the social indicators are taken together, *all countries have shown progress during the last 25 years.*

At its lowest, *life expectancy* was 40 years in 1970 and at its highest ó4. By 1993 the lowest level of life expectancy had risen to 48 and the highest to 72. As might be expected, the relative mortality indicators have improved correspondingly.

The highest rate of infant mortality for this group of countries was 178 in 1970. It had declined to 129 in 1992.

Rapid progress had been achieved in *education*. Several countries had reached full or near full participation in primary education. The lowest rate of enrolment in primary education in 1970 was 6. In 1992 it was 25. *Adult literacy* also showed improvement for all countries although high levels of illiteracy continued to prevail in several countries.

The levels of *undernutrition* had fallen for all countries of the Region during the last 25 years, although they continued to worryingly remain high for several. Generally speaking, the falling trend is South East Asian countries (Thailand, Indonesia) is faster than in South Asian countries.

A larger proportion of the population had access to safe water, sanitation and health care.

Birth rates have fallen and *rates of fertility* have dropped. In 1970, birth rates ranged from 30 to 48 per thousand population. The range in 1993 was 19 to 39. The corresponding figures for the range of fertility rates were 4.3 to 7.0, and 2.1 to 5.3.

Although there has been substantial improvement in social indicators for the Region as a whole, in several countries the progress has taken place from conditions which have been among the least developed and poorest in the developing world. However, for the Region as a whole, some important concerns need to be summarized:

- nearly *45% of the adult population are still illiterate*;
- nearly *80% of the population have an average life expectancy* between 54 years and 61 years – that is a life span *lower than the average for industrialized countries by 23 years to 16 years*;
- according to available data, approximately *40% of the Region's population live in absolute poverty*, mainly in

South Asia. The poor as a proportion of the population range from 52% in Bangladesh to 17% in Indonesia;

- the proportion of *undernourished children under five years of age range from 63% and 66% for the most populous countries, which together contain a population of about one billion or about three-quarters of the Region's population.* The rates of child undernutrition in the other countries are still rather high, ranging from 33% to 51%. In only one country, Thailand, is the rate in a much lower range (13%).

The rates of progress vary considerably among countries and among indicators within countries. These provide some insights into the processes which underly these varying rates of progress and the links that exist among the various indicators. These aspects are dealt with in some detail in the third part of this paper. The number of years added to average life expectancy range from 16 years for Indonesia, from a low life expectancy of 47 years in 1970, to 8 years for Sri Lanka which already had the highest life expectancy among SEAR countries in 1970 (64 years). Countries with the lowest rates of adult literacy in 1970 did not have more than a quarter to a third of the adult population literate even in 1993. The increase in the enrolment in primary education in most of the countries has expanded rapidly during the last 25 years. This holds out prospects of a rapid rise in adult literacy in the future, provided female literacy can be urgently improved. The data relating to improvements in access to health care, safe water, and sanitation are not quite adequate to draw firm conclusions regarding the comparative rates of progress among countries. Available data, however, show that progress in these areas has not been even. In the case of several countries, the performance on one indicator is satisfactory while on another it is poor. In one country, for example, the proportion of the population with access to safe water appears to have risen to nearly 80% while access to sanitation is still at a low level (16%). In contrast, the proportion of the population with access to sanitation in another country

(55%) is significantly higher than the percentage with access to safe water (42%). The availability of health care, as measured by population per physician, has improved rapidly in most of the countries. The rate of decline in fertility has been highest for Thailand (from 5.5 to 2.1).

Social Indicators for Countries Based on Levels of Life Expectancy

It is difficult to group the countries according to common profiles of indicators. If life expectancy is taken as the key indicator, countries with a life expectancy of 58 years and below can be taken in one group, while countries with life expectancies between 60-65 years and high life expectancy countries (close to and above 70 years) can be put in a second and third group, respectively. However, countries in each grouping do not share common profiles of social indicators.

In the first group, for example, Nepal, Bangladesh and Bhutan have low per capita income, low life expectancy, high levels of poverty, high rates of fertility, high rates of illiteracy, particularly female illiteracy, lower life expectancy of females compared to males, and a poor infrastructure of basic health, water and sanitation services. For Nepal and Bangladesh the proportions of the population living in poverty are the highest for the Region, (approximately 52% for Bangladesh and 40% for Nepal). Large family size, frequent and too closely spaced pregnancies, illiteracy, poor maternal and child health status and care, poverty and undernutrition are all inextricably linked together and reinforce each other.

While sharing some of these characteristics, Myanmar has a much higher rate of adult literacy (82%) than the other countries in this group. In addition, Myanmar has a lower rate of infant mortality and fertility, and a much higher daily per capita supply of calories than the other countries in the group. Female life

expectancy is higher than male, a positive indicator of the status of women. With the highest life expectancy in this group, it shares some characteristics with the second group. This probably demonstrates the way in which literacy and the improvement in women's status can act independently to raise the level of well-being.

The three countries in the life expectancy range of 60 to 65 years include India, Indonesia and Maldives The profiles of the two large countries indicate they are in the stage of transition from high fertility and high infant mortality to lower levels of fertility and infant mortality. Indonesia is making this transition faster. Although in terms of average life expectancy, the difference between the two countries is small, Indonesia is ahead in other indicators, for example infant mortality, total fertility rate and child malnutrition. Maldives is still at the stage where the rapid decline in mortality is not matched by a corresponding decline in fertility, although Maldives has, together with Thailand, the highest literacy rate in this Region. All three countries have an average per capita supply of calories above the minimum. Indonesia and Maldives, however, have a much larger per capita supply than India. There is considerable variation in the access to health care, water and sanitation. Indonesia, with a higher life expectancy than India, has a lower ranking for population per physician, access to safe water, and prenatal care and care at birth. The levels of poverty for this group of countries is lower than those of the first group. Nevertheless, the proportion of the population in poverty in India (31%) is nearly double that of Indonesia (17%), which has the lowest proportion in the Region. With regard to demographic characteristics, Maldives deviates from the normal trend in that it has had rapid growth of per capita income and a high level of adult literacy, including female literacy, but without a corresponding decline in fertility.

Among the three countries with high life expectancy, Sri Lanka is exceptional in that it is in the low income category

with a per capita GNP much below Thailand's. It shares several other positive social indicators with the other countries, e.g. high rates of adult literacy for males and females, higher female life expectancy and access to health care. Malnutrition is however significantly higher than in Thailand. The proportion of the people in poverty (22%) is higher than Thailand (19%). The infrastructure for basic services for water and sanitation is less developed than in Thailand. Daily calorie supply per capita is also well below Thailand's. Data for the Democratic People's Republic of Korea on many of these indicators are not available for comparison.

Simultaneity of Progress

There are a few basic conclusions which can be drawn from this brief analysis of social indicators at national level. For the majority of countries, social indicators and per capita incomes seem to be progressing together. This means, generally speaking, at each higher level of life expectancy, higher per capita incomes and higher social indicators could be expected. There are possible exceptions from this general trend. Myanmar, for example, has a high level of adult literacy, while some other social indicators are quite low. Sri Lanka has high levels of malnutrition and poverty, while performing very well on most other social indicators such as literacy, fertility and life expectancy. Thailand, with the highest per capita income in the Region, has a slightly higher proportion of the population living in poverty than Indonesia (and not much lower than Sri Lanka). *The general trend suggests that progress of each indicator needs simultaneous advancement on a whole range of other social and economic indicators. The deviations from the general trend are also illuminating. They can demonstrate how progress, or lack of progress, in any one critical indicator affects the total level of well-being. Part three of this monograph examines some of these issues in greater depth and discusses their implications for the improvement of health status.*

ECONOMIC PERFORMANCE AND MACROECONOMIC POLICIES OF THE REGION

THE SOCIAL situation in the Region described in the foregoing section has to be considered within the framework of economic development and macroeconomic policy. Table 2 at Annex B presents the main macroeconomic indicators. It provides an overview of long-term economic performance of the Region during the last two and a half decades. There are significant differences among countries with regard to their macroeconomic policies and development strategies. The differences in the social indicators and the levels of well-being could be partly attributed to differences in these policies. From the perspective of macroeconomic policies and economic performance, countries can be placed in two broad groups. Countries which progressively followed the path of liberalization over a long period succeeded in sustaining high rates of growth. Other countries have been moving at varying pace since 1980s from inward looking, planned and controlled economies towards liberalization and privatization. Their rates of growth have moved from low to moderate and, in some cases, higher than moderate in recent years.

The analysis of macroeconomic development trends points to the following general conclusions:

- Countries which have been best able to sustain rapid economic growth over the long term have also been able to achieve significant improvements in their social indicators.
- The shift towards liberalization and privatization in other countries has been accompanied by higher rates of economic growth and improvements in social indicators but progress has been slower.
- The experience of the countries in the Region, therefore, leads to the conclusion that alleviation of poverty and improvement of the health status need a macro-economic

policy framework conducive to rapid growth with equity.

- Within such a framework, the best performers have been those who simultaneously developed their human resources by investing in, and raising the levels of, education and health. The macroeconomic performance of this group of countries indicates that high economic growth and rapid improvement of human resources must reinforce each other. Growth is therefore more likely to be sustainable if it is accompanied by equity.

THE LINKAGE BETWEEN POVERTY AND HEALTH

BASED ON the analysis in the preceding two parts, it is possible to make some generalizations on the relationships between economic growth, poverty reduction and improvement of health status. First, it is possible to draw initial conclusions regarding the manner in which health indicators move in relation to the reduction of poverty by examining observable changes along the gradations of income among countries in the Region.

Simultaneous Movement of Indicators

The first set of critical questions that are raised concern the relative importance of the income variable and other variables. To what extent is an upward movement of non-income variables dependent on the upward movement of per capita income and to what extent is the dependence reversed? The data provided in Tables 1.1–1.4 and 2 for the past trends within each country help us identify broad patterns for a wide range of indicators. Some tentative conclusions can be drawn.

We noted in the first part of this monograph when key output indicators in health (such as life expectancy, infant mortality and fertility) and education (such as adult literacy and primary school enrolment) are examined in relation to countries' per capita GNP, they show progressive improvements. This is true for most, as we move from the country with the lowest per capita income to the country with the highest. For most countries, health, reduction of poverty and a number of other socioeconomic and demographic variables therefore seem to be moving together. The simultaneous improvement in these variables can be observed both within countries as they increase their per capita incomes, as well as among countries at different levels of per capita income. It could be said that with every increase in per capita GDP, some improvement in all other variables is observed. Equally, it could be said that with every increase in life expectancy or adult literacy there has been some improvement in income and other variables. This pattern of simultaneous movement has important implications for the approach to the links between poverty alleviation and health.

In countries with the lowest per capita incomes, poor health coexists with poverty. Poor health coexists with a lack of capacity in many other dimensions. These include lack of economic resources, lack of education and skills, inability to manage the reproductive life and lack of access to basic services. Poverty is clearly multidimensional. Moving out of multidimensional poverty requires more resources and capability in all these areas. The relationships and interdependence of the indicators seem to be such that they all progress together even though the rates of progress may vary from indicator to indicator.

The main issue concerns the nature of this simultaneity. Do all the non-income variables such as health and education follow the movement of the income variable? Or must the variables move together, for any single variable (including income) to perform satisfactorily? If it is the latter, then the relationship between income and non-income variables is much more complex.

In such a relationship, they would be mutually supporting and constantly interacting with each other to produce a concerted movement forward.

Deviations from the Regular Pattern

A fair degree of simultaneity appears to be the regular trend. However, irregularities occur where individual countries are outside the trend for selected indicators. These emerge when one or more key indicators lag behind and when progress on these is inordinately slow or lacking altogether. The irregularities are revealing and throw light on what happens when indicators *fail* to move together.

Irregularities in the simultaneous upward movement provide a point of entry to some of the relevant issues. Irregularities emerge when countries are ranked in relation to their variables. Ranking according to per capita income is not identical with the ranking on the other variables. The most striking of these irregularities are the following:

Sri Lanka, which is 5th in per capita income, is first in life expectancy and in related variables such as infant mortality.

Myanmar has an adult literacy rate of 82% and is 4th, while in per capita income it ranks much lower.

Maldives is 4th in terms of per capita income and shares the first place with Thailand in adult literacy, but its ranking is lowest in fertility decline.

Thailand has the highest per capita income, but has a significant proportion of the population living in poverty (19%), compared with 22% for Sri Lanka, which has a much lower per capita income.

India has a life expectancy close to that of Indonesia and Maldives, although its per capita income, whether in US dollars

or Purchasing Power Parity dollars, is well below those of the other two countries.

When the other indicators are examined in each of these cases, some of the factors underlying the irregularities emerge. In the case of Sri Lanka, despite high life expectancy, the low per capita income is associated with high levels of child malnutrition and poverty. Child malnutrition, in terms of wasting and stunting, is unusually high for a country with as low a rate of infant mortality and as high a life expectancy as Sri Lanka. Large-scale welfare programmes and safety nets have not been able to bring these levels down significantly from those which prevailed in the early 1970s. Malnutrition, poverty and slow growth of per capita incomes are closely interlinked. Sri Lanka's large-scale public expenditure on social welfare, investment in health and education have produced high social indicators, high levels of female literacy and universally accessible maternal and child health care services. Together, these provided the capacity for survival and the maintenance of a minimum level of well-being. The level of income and material well-being has not been sufficient, however, to eliminate poverty and malnutrition. These conditions reflect the imbalances in development strategies and allocation of resources which enabled the state to intervene directly to raise the social indicators but neglected the growth of income-generating capacity and employment which would have increased the self-reliance and capability of households. This underscores the centrality of health to development and the need for integration of health and socioeconomic strategies.

Myanmar's high rate of literacy has not by itself been sufficient to make commensurate progress in economic and some other social indicators. The crucial factor which prevented the country from gaining full advantage of the human resource development reflected in its high level of literacy has been the decline of the economy. Myanmar's economy did not grow in the 1980s, with negative per capita income growth during this period. Yet despite these developments, life expectancy, infant mortality and

fertility continue to be better than in some other countries with similar per capita income. These conditions illustrate how the quality of the available human resources has been able to move some social indicators forward despite severe economic stress and even decline of per capita income. The available human capital appears to play a part independent of the factors relating to income. Myanmar has been able to protect some of the essential elements in primary health care such as immunization, prenatal care and care at birth. Malnutrition has been lower than in India, Bangladesh and Nepal. Myanmar also appears to have had the advantage of an agricultural sector enabling to maintain a daily supply of calories above other countries in the Region. These variables have acted in combination, independently of the decline of income, to sustain the levels of well being already achieved and improve some. However, in the absence of economic growth it was not possible to make significant advances and raise the level of well-being as a whole. While Bangladesh and Nepal added 14 years to their life expectancies during 1970-1993, Myanmar added nine.

In countries with a combination of high income growth and human resource development, including female education, the demographic transition to low fertility and low infant mortality has been rapid. Thailand and Indonesia exemplify this point. In the Maldives, the indicators for health and education have advanced rapidly along with high economic growth. However, reproductive behaviour did not change correspondingly.

In Thailand,the persistence of a fairly high level of poverty relative to the level of per capita income points to another set of issues. Growth of income, while necessary for the alleviation of poverty, is not sufficient to reduce it rapidly. The distribution of income, reflected in the ratio of income shares of the highest and lowest 20%, shows a widening gap between rich and poor. Regional inequalities have contributed to this situation. Thailand has three times the per capita income of Sri Lanka (more than double in terms of the PPP$ income) but lower life

expectancy and higher infant and maternal mortality rates. Inequality in Thailand is moderate in comparison with some other developing countries (e.g. in Latin America). Nevertheless, it demonstrates that within a macroeconomic environment of high growth which relies mainly on market forces, special attention needs to be given to the alleviation of poverty and the gap between rich and poor. Policies and interventions have to designed and implemented equitably to ensure development and growth are "poor-friendly". If high growth leaves a sizeable residue of poverty then the full improvement in health status possible with the given level of growth cannot be secured.

The way in which social indicators have advanced in the case of India is also revealing. While its economic performance has been below Indonesia's and the Maldives', it has been quite close to them in life expectancy. India has been able to make moderate advances on all the social indicators, adult literacy, infant mortality, life expectancy, fertility as well as in reduction of poverty and increase in per capita income. This can also be measured by the human development index (HDI, Table 1.5). India ranks higher in HDI than in per capita income (PPP$).

Salient Issues

A few important conclusions emerge from the experience of countries which are relevant for the improvement of health status.

- Poverty is most often defined in terms of current income. The poor are identified as those whose current incomes are insufficient to satisfy the minimum nutritional requirements and other basic needs. The "current income" concept assumes that low income will adequately reflect deprivation in all other forms. It is indifferent to numerous other non-economic variables which combine with economic ones to produce the inadequate current incomes of the poor.

- The "current income" approach concentrates on the economic dimension of poverty. It tends to neglect, first, the central place of human resources in poverty and, second, the collective nature of poverty in relation to the social and economic infrastructure. The lack or deprivation of human resources – low levels of education and poor health - reduces income earning capacity and perpetuates poverty. Deprivation of human resources has to be seen, therefore, not as a derivative of "income poverty" but as an independent dimension of poverty contributing to income poverty. Poverty needs to be perceived holistically as poverty of "well-being". Poverty of health, of knowledge and skills, of literacy and education, of environmental well-being and of income generation are elements of a total condition, in which people lack an entire range of essential resources, human and material.

- It is possible to trace the links between poverty and health by examining the way in which inputs to health directly related to income interact with the inputs to income directly related to health. The relevant set of inputs to health will include income to obtain food in adequate quantity and quality, supply of safe water and sanitation. This will again be related to economic conditions of the household and the socioeconomic infrastructure of the community in which the household lives. Capacity to access health care will depends on household income to meet health expenditures (preventive, curative, family planning, transport etc.). It also depends on income and resource levels of the state and community to provide infrastructure of preventive and curative health care as well as infrastructure to access it. The health-related inputs to income will be physical and mental health to engage in productive work of all types, to maintain care and services of the household to sustain productive income earning work, to limit family size and raise per capita family income. This would be the direct interrelationship in which there is a circular flow of inputs to health and income. However, health and

income and most of the variables in the two sets are related to another key variable: education and its inputs. Female literacy, for example, proves to be a key variable in both health and income. All three sets of variables interact continuously with each other.

- The way in which all the key variables tend to move upwards together points to "simultaneity" of the advance as a key factor in the improvement of well-being. The different factors of well-being, i.e. income-related factors, health-related factors, educational and demographic factors, seem to generate a system of supply and demand within which they interact continuously tending to move towards an equilibrium.
- The simultaneous character of the progress made by the key social and economic indicators implies that improvement of health status must be accompanied by improvements in many other conditions of well being. The deprivation in health cannot be alleviated without simultaneously alleviating many other conditions of deprivation. A major part of any strategy for poverty alleviation must focus on all those processes which improve the human capital of the poor – health, nutrition, knowledge, skills, literacy - both in terms of households and the community.
- Deviations from the average pattern draw attention to some special characteristics in the relationship between different variables. Improvements in well-being appear to be affected by processes at two levels. At one level, the combination of well-being through increases in income, life expectancy and health, education and demographic changes appear to be interacting and producing a synergistic impact and accumulating a fund of human capital which contributes to the simultaneous forward movement of all the key variables. At the other level, there are service inputs into each condition of well-being, such as access to health care, water and sanitation, to improve health. This requires both the physical capital in

the form of infrastructure at the level of the community and the capacity of the household to access and use it. In conditions of poverty when output indicators are low, the second level becomes critically important.

- *The condition of deprivation is one in which poverty of households is integrally linked to collective poverty of communities.* Poverty, when measured in terms of the household and the individual, focuses on resources directly available to these units. But *part of the poverty of households and individuals derives from the collective or community poverty in which they exist, that is inadequate economic and social infrastructure, lack of communal amenities for sanitation, water, health care, education and the environment.* The processes which alleviate poverty have to be powerful enough to remove these *collective* elements of poverty. Their removal requires strategies capable of distributing improvements in well-being equitably throughout society. Then it must transform both the backward parts of the economy and the weak social infrastructure which produce poverty. Public investment to improve *access* to health care, water, sanitation, education and income generation would have to be substantial. Such investment is essential for future growth. It is therefore cost-effective.

- A fuller understanding of these processes becomes critically important for policies relating to health and poverty alleviation. In certain situations as a certain key variable lags behind, this variable becomes the trigger to renew the process of poverty alleviation. The "trigger" variables are different for different situations depending on the existing disequilibrium. The circuitous nature of the path to poverty alleviation and well-being will of course vary among countries.

For several countries with high mortality, high fertility and high female illiteracy, the path may lie by female education, better spacing of births, smaller family size, better health and education of women and children, increase in the productive

labour available to the household, new and higher income generating capacity.

If a country has high literacy and high fertility, the approach may require a combination of initiatives which relate to reproductive behaviour, health, gender equity (female employment in particular).

If a country has high social indicators co-existing with poverty, unemployment and malnutrition, strategies are necessary to enhance the income-earning capacity of poor households with emphasis on health and nutrition.

In higher income countries, strategies often need to focus on improving income distribution, reducing regional or rural disparities and directing market forces to those regions which are lagging behind.

In all these scenarios, equitable education and health systems provide essential foundations to overall socioeconomic development.

These observations underscore the need for an approach which identifies each of the key "output" variables: gender equity, health status, economic well-being, including income and income earning assets, availability of shelter, water and sanitation, levels of literacy and education, participation in the decision-making affecting one's own well-being as integral parts of a condition of total well-being towards which each of the variables must move. The poverty-health link has to be defined and understood within that condition. The policies relating to each key variable would have to be tailored to the prevailing disequilibrium. The Chart at Annex C attempts to relate the relationship between the different resource bases needed for well-being, the processes which produce or reduce poverty, and the outputs resulting in improvement, stagnation or loss of well-being. Each set of variables is linked by a two-way relationship. Variables are linked to each other by circular relationships. The linkage between health and poverty needs to be identified and managed within this system. The analysis

developed in this monograph may help to evaluate the country situation: in terms of specific disequilibria, and in designing appropriate strategies.

POLICY IMPERATIVES AT THE MACRO LEVEL

THE BRIEF summary of socioeconomic development in part two emphasized the decisive role played by macroeconomic policies in setting the pace for simultaneous advancement of key variables which produce well-being.

Macroeconomic policies therefore must be guided firmly by the fundamentals which ensure economic growth and social development go together. While pursuing policies of prudent macroeconomic management, special efforts are required to achieve this combination.

The following discussion examines some salient issues on the mobilization and allocation of resources in the light of the linkage between health and poverty. For this purpose, some of the policy imperatives are examined at macro-level. Thereafter, some specific issues concerning the mobilization of resources for health and poverty alleviation are discussed.

The imperatives at the macro-level include the following.

First, the processes of structural reform and allocation of resources must be guided not only by macroeconomic fundamentals but also by social fundamentals. Improve and protecting a society's human resources requires adequate investment in health and education. Each country in the Region would need to define these social fundamentals in relation to its state of health, education and the prevalence of poverty. In

general, social investment is necessary because future growth and productivity depend on it.

Second, in addition to mobilizing larger domestic savings and increasing public revenues, countries would need to identify the areas where there is potential for reallocation of resources. Countries could use the opportunity of structural reforms to restructure the public sector. For example, state-dominated regimes may have resulted in top heavy administrative structures. Clearly, these allow room for economies and reallocation of available resources within the existing public sector. Such efficiency gains could actually lead to an expansion of the public sector's contribution to develop the national socioeconomic infrastructure.

Third, the criteria for resource allocation at the national level must take account of the overriding importance of protecting health as the foundation for survival and productive work in poor countries. The allocation for health (especially public health) has to be in the nature of a "preferential share" of the public resources available. The core resources for health, and within this the minimum resources needed to sustain an effective system of health care, should be clearly identified. There should be a firm national commitment that such essential public health functions will have prior claim on available resources. The inter-country comparisons show poor countries which have achieved a relatively high level of access to health care, water and sanitation. Their experience in developing a low cost social infrastructure accessible to the poor will be of value to countries which have not yet been able to do so.

Fourth, part of the explanation for variations in health outcomes at similar income levels lie in the way in which health related resources themselves are allocated and managed. This applies to national as well as household levels. A poor household which has learnt to use its scarce resources wisely on the main elements of preventive health – better food and nutrition, a clean household, safe water, improved sanitation – will be healthier than a household at a higher level of income which neglects preventive

health and consequently spends more heavily on curative care. The former has the resource base in health to move out of poverty, the latter lacks that resource base and for that reason can lapse into poverty.

The health knowledge and health behaviour which enables households to manage the scarce health related resources at given levels of income might therefore well be decisive in the alleviation of poverty. Interestingly, where women have greater control over household expenditure, they are generally more likely than men to spend on health, nutrition, education. This is an indication of the importance of advancing female skills and opportunities. Similarly, a government which allocates health-related resources prudently, prioritizing primary and preventive health care, will improve the health status of the population more rapidly than if the emphasis is costly curative care.

Fifth, several countries experienced either stagnation or decline in the well-being of the poor during periods when economic restructuring is attempted. Nevertheless, access to markets is a decisive factor in poverty alleviation.

Many countries found that a broad-based strategy of development which combines economic growth with human resource development, by expansion of primary education and primary health care, does not by itself enable the poor to move out of poverty at the necessary pace. As was seen in the analysis, Thailand has a substantial residue of poverty despite rapid growth and investment in education and health. However rapid the growth, there is a long time lag in the alleviation of poverty. As average incomes increase, concomitant discontent generated by poverty (even if the proportion is declining) could pose problems. Societies must address these. Experience in this Region suggests that micro-level interventions are necessary, clearly targeted to the poor. Therefore, the development strategy at macro-level should provide a key role and adequate resources for such micro interventions.

Sixth, micro interventions require multisectoral design and implementation. This is essential as "income poverty" is inextricably linked with other conditions of deprivation such as poor health and lack of education and knowledge. Interventions need a community base with active participation of the poor (in planning and implementation).

Seventh, in order to realize the full potential of such programmes, vulnerable groups in countries and the special nature of their poverty or vulnerability should be identified. For instance, scarcity of fresh water in arid climates or small island environments, inaccessibility of mountainous and remote regions, sociocultural or socioeconomic constraints leading to high gender disparities. Country would find it beneficial to develop a typology of vulnerable groups together with a sustainable strategy for upliftment.

INTEGRATING HEALTH WITH POVERTY ALLEVIATION

THIS PART illustratively examines some of the issues relating to micro-interventions for poverty alleviation and their implications for health. Innovative programmes at the regional and national levels have been able to build health as part of integrated programmes. In these, increase in income earning capacity and propensity to save, education and skill development, water and sanitation, sustainable use and protection of ecological resources are linked to health. From the outset, programmes focus on the multidimensional character of poverty. Efforts were directed at any single determinant were undertaken as part of an integrated whole. Some of the illustrative initiatives are given below.

Bangladesh has two well developed programmes initiated and managed by NGOs which are being implemented on a

country-wide basis. These are the programmes of the Grameen Bank and the Bangladesh Rural Advancement Committee (BRAC). The Grameen Bank, initiated as an informal credit programme, was formally established in 1983. It has had remarkable success as a credit institution for the poorest households who are excluded from the formal credit system for lack of material collateral. The bank provides general loans to individuals (especially women) against group guarantees. It also grants collective loans for joint enterprises and provides long-term credit for housing. Mobilization of savings is an integral part of lending. Each beneficiary is required to save in several different accounts such as the group and emergency funds. The Bank has steadily expanded and covered about half the villages by 1994 and had a membership of over 2 million. A staggering 94% of *beneficiaries are women.* The Grameen Bank has been financed by external and domestic sources, such as the International Fund for Agricultural Development and the Central Bank of Bangladesh, at concessionary rates of interest.

BRAC was established in 1972. BRAC implemented a number of multisectoral programmes aimed at poverty alleviation and empowerment of the poor. Two of its major programmes are the Women's Health and Development Programme and the Non-formal Primary Education Programme. At present, BRAC runs more than 28,000 schools with a three year course for basic literacy and numeracy for the poorest rural children who are *not* reached by the formal school system. The BRAC programmes attempt to deal with two of the main conditions of deprivation closely linked to the extreme poverty in rural Bangladesh. The main beneficiaries are women and children.

In *India*, from the wide range of community-based programmes of poverty alleviation, two well known programmes are the Self Employed Women's Association (SEWA) and the Maharashthra Employment Guarantee scheme. The former is an association of poor women drawing its membership from three types of labour: largely self-employed (small vendors and traders), women engaged

in home-based production and casual labour. Starting as an urban organization, SEWA has expanded into the rural sector as well. The main objective of SEWA is to enhance the working opportunities and income of self-employed women, organize savings and credit co-operatives for providing working capital to its members, organize producer co-operatives for obtaining prices for their products, impart training and provide legal aid. It has been able to develop schemes for material protection, widows' benefits, child care and training of midwives. Its activities cover credit and savings, income-generating activities and social welfare, *including maternal and child care needs*. With focus on women and a multisectoral approach to the alleviation of poverty, SEWA represents a valuable model of NGO activities.

The Maharashthra Employment Guarantee scheme has been widely commended as a safety net for the unemployed. It provides guaranteed employment within five kilometres from beneficiaries' villages at a stipulated wage. In 1991, the programme had disbursed about $103 million. About 62% of workers in the programme came from households below the poverty line. Despite a number of weaknesses mentioned in evaluations of the programme, it is recognized as one of the more cost effective schemes for helping poor households whose poverty is mainly caused by unemployment.

In India, the government implements a minimum needs programme on a country- wide basis. Out of the 12 broad programme components, six relate to health directly: rural health, rural sanitation, rural water supply, rural housing, nutrition and environmental improvement of slums. The focus is on poorer sections of society, who predominantly live in rural areas (and also in urban slums). The remaining six components (such as rural electrification, rural roads, civil supplies, elementary and adult education) contribute to health and overall social development. The various components of the Minimum Needs Programme are built into the annual

plans of the States. Approved outlays for such components are not allowed to be diverted to other programmes or schemes.

Sri Lanka has a long history of state-financed poverty alleviation programmes as well as non-governmental initiatives. The present *Samurdhi* programme replaces the major income transfer programmes which were in operation for a long period – the Food Stamp scheme and the *Janasaviya*. The *Samurdhi* programme attempts to rationalize the welfare system as a whole by focusing on credit to the poor and enhancing their income-earning opportunities. It also plans to draw on the more positive elements of the schemes it replaces – in particular their multi-sectoral approach. The *Janasaviya* Trust Fund (JTF), established as a financing institution for the poor linked to the *Janasaviya* programme, sought to integrate five components in its poverty alleviation programme. These include social mobilization of communities (which motivates them to develop and move out of poverty), the development of economic infrastructure of the poor communities, a public works programme to absorb unemployed youth, a nutrition and human resource development programme to improve the health and physical well being of vulnerable groups and micro-enterprise development to promote income generating self-employment. The philosophy of JTF recognized the multidimensional aspects of poverty, tackled simultaneously.

A separate Ministry is entrusted with the responsibility for the National Prosperity Programme. The services and assistance of rural development banks, *Sanasa* (a co-operative lending institution), NGOs and the private sectors have been harnessed to supplement state support. Participatory institutions have been set up to supervise and monitor progress. Coordination and monitoring of the prosperity programmes at the local, district and national level are being done by a network of non-bureaucratic institutions.

The programme called the *Suvasaviya* – the health version of the *Janasaviya* – added several elements to the primary health

care programmes at the micro-level. These included community based information systems, local level epidemiological surveillance systems, appropriate packages of health education material, systems for monitoring health care services designed and implemented by the community. In concept, *Suvasaviya* proved an effective way of mobilizing a community around well defined health goals and entering into the larger programme to improve well-being. In implementation, *Suvasaviya* was limited to eight divisions and therefore limited in its reach. Evaluation of the programme indicates that it was successful in some of its main objectives. It was able to get households to spend more on health improving investments such as housing, water, sanitation and nutrition and thereby strengthen the foundation for both improving and sustaining their well-being. Integrating health with poverty alleviation in this manner sets in motion a process which enhances the human capital of households and communities and increases their capacity to move out of poverty.

Sri Lanka has a number of large-scale NGO initiatives for poverty alleviation. These offer valuable knowledge and experience. The *Sarvodaya* programme has a large multisectoral agenda encompassing social mobilization, health and nutrition, micro-enterprise development, financing and skill development. *Sanasa*, effectively a programme of savings and credit, has a country-wide network of self-reliant thrift and credit societies managed by the beneficiaries. *Agromart*, an NGO mainly for women engaged in small scale enterprise, provides a wide range of services to members.

Indonesia has a wide variety of micro-level initiatives for poverty alleviation taken by both the State and NGOs. Two better known credit programmes are designed for lending and saving to mainly female micro-entrepreneurs, undertaken by the Bank Rakyat (a government bank) - *Kupedes* which provides loans, and *Simpedes* which mobilizes savings. The poverty-oriented savings and lending programme is built into the commercial banking system with national outreach. As a result,

the programme is able to serve a large clientele on a country-wide basis. The *Baden Kredit Kecamatan* (BKK) is a nongovernmental credit and savings programme for small borrowers and savers. It operates with government support and serves areas not reached by other financial institutions. No collateral is required. The programme has a highly decentralized structure. It is organized through sub-district financial boards and village committees which operate with the guidance of village leaders. It is self-reliant, relying mainly on savings deposits, charging commercial rates of interest on loans. In 1982, it was already serving 2.9 million people.

Another example of community-based effort to address poverty alleviation, intersectoral in scope, is the programme to upgrade kampongs in Jakarta. This programme benefits the urban poor. It was organized by the municipality in 1969, and initially undertook replacement of temporary dwellings and improvements of infrastructure such as roads, drainage and water supply. As the programme grew, further components were included: disposal of solid waste, construction of sanitary facilities, promotion of horticulture, health training and vocational and non-formal education. It clearly became a multisectoral effort at improving living conditions, especially appropriate for the urban poor in shanty environments.

Thailand developed a basic needs approach. With the acceptance of primary health care as a priority programme in national health development, and in the context of national socioeconomic development, the Royal Thai Government incorporated basic needs at various levels in the PHC programme. Simultaneously, a poverty eradication programme was initiated to improve the socioeconomic conditions at the grass root level. In time, the basic needs served as the main entry point for intersectoral action for health development at peripheral levels, with the Ministry of Public Health providing technical leadership. Within the framework of PHC, technical cooperation among developing villages (TCDV) was promoted through networking. Community resources were mobilized for village health

development through intersectoral coordination. During 1980s, the poverty eradication programme became a comprehensive community development scheme, and part of overall socioeconomic development plans.

The *Ayadaw* Township Development Programme of *Myanmar* commenced in 1976 with health intervention programmes such as construction of sanitary latrines for each household, water supply through tube wells for every village, full coverage of immunization and deliveries by trained health personnel, and prevention and control of leprosy, plague (etc). This initiative has since been extended to about 100 townships covering about 40% of the population. Sinking of tube wells has created irrigation facilities resulting in agricultural prosperity. Replacement of fire wood for domestic source of energy by waste materials has led to environmental protection, and economic prosperity contributing to health development. The basis of the programme is community action in health, which contributed to sustainability of social development.

There have been a number of integrated atoll development programmes in the *Maldives*. While not specifically designed to alleviate poverty, the aim was to address the substantial disparities between the capital island and outer atolls. These initiatives included health and training components, as well as loan schemes, thereby linking improvements in basic social services with socioeconomic opportunities in atolls where credit facilities had hitherto been unavailable.

The above illustrative list of micro-level programmes can be expanded with examples from other countries in the Region. Both Indonesia and Thailand have been able to link the large-scale private sector to the effort at poverty alleviation. Such linkages are present at certain places in India, and they are growing and expanding. Under these initiatives, large private sector firms "adopt" poor villages not merely for humanitarian activities within the villages but also to stimulate economic activity and link them to the mainstream market economy.

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Annex A

Table 1.1
Demographic Indicators in SEAR Countries

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
Life Expectancy at Birth*	1993	Years	61	63	56	58	54	72	69	71(92)	48	62
	1980	"	52	53	47	54	44	68	63	68	44	58
	1970	"	48	47	42	49	40	64	58	62	41	52
Total Fertility Rate	1993	%	3.7	2.8	4.3	4.1	5.3	2.4	2.1	2.4(92)	5.9(92)	6.0(92)
	1980	"	4.9	4.5	6.4	5.3	6.4	3.6	4.0	2.8	5.9	6.8
	1970	"	5.5	5.3	7.0	5.9	6.1	4.3	5.5	5.7	6.0	7.0
Crude Birth Rate	1993	Per 1000 Popu.	29	24	35	32	39	20	19	24(92)	39.6(92)	41.6(92)
	1980	"	36	35	47	37	44	28	30	..	..	..
	1970	"	39	40	48	40	45	30	38	..	..	..
Crude Death Rate	1993	Per 1000 Popu.	10	8	11	11	13	6	6	5(92)	15(92)	9(92)
	1980	"	14	13	18	13	20	6	8	..	..	..
	1970	"	16	18	21	17	22	8	10	..	..	..
Infant Mortality Rate*	1993	Per 1000 Live Births	80	56	106	82	96	17	36	24(92)	129(92)	55(92)
	1980	"	123	105	136	101	150	44	55	30	154	80
	1970	"	137	118	140	128	157	58	73	47	178	112
Under 5 Mortality Rate*	1993	Per 1000 Live Births	122	111	122	111	128	19	33	28(92)	197	73(92)
	1988	"	149	119	188	95	197	43	49	33	197	..
	1970	"	..	..	140	..	..	..	..	..	..	..
Maternal Mortality Rate*	1988-93	Per 100000 Live Births	420	450	600	518 (89-95)	..	30 (89-95)	155 (89-95)	41 (92)	1310 (80-92)	480(92)

.. Not Available

Note. The figures given are not fully comparable as they are from different sources, and different periods of reference due to non availability.

Source: World Dev. Report 1982, 1995 & 1996 - World Bank
Human Dev. Report 1990, 1994 & 1995 - UN
World Tables 1980 & 1994 - World Bank
Social Indicators of Development 1994 - World Bank
Economic & Social Survey of Asia & Pacific 1996 - UN

Table 1.2
Indicators of Health and Nutrition in SEAR Countries

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
Low Birth Weight Babies	1991	%	30(90)	8(90)	34	13	26	22	10	..	.	20(90)
Population per Physician*	1993	Nos.	2439(91)	7143(91)	5220	12900	16110	7143(91)	4420	370(90)	13112(92)	14333(92)
	1980	"	3640(78)	11530(79)	10940(79)	4660(79)	30060	7170	7180(79)	..	23308	15000
	1970	"	4950	27440	8450	8820	52050	5900	8290	..	..	28500
Malnurished Children Under 5 Years	1990	%	63	38	66	33	51	42	13	..	..	..
	1975	"	71	51	84	41	63	58	36	..	..	56(90)
Married women of child bearing age using contraception*	1993	%	43	50	40	..	23	62	66	..	.	..
	1980	"	23(81)	27(79)	12	..	4.3(77)	41(77)	59(81)	..	..	..
	1970	"	12	0.2	8(75)	..	0.7	8(71)	8	..	..	..
One Year-Olds Immunised	1992	%	90	92	69	74	73	88	86	96	85	98
	1987	"	63	71	18	24	71	79	79	59	67	..
Births Attended by Health Personnel	1985-90	%	75	44	7	94	6	85	71	..	11	..
Pregnant Women Receiving Prenatal Care	1988-90	%	70	47	40	90	9	86	53	..	63	47
Daily per Capita Calory Supply	1992	kcal	2395	2755	2019	2598	1957	2275	2443	..	2834	2624
Population With Access to Health Services	1993	%	..	64(92)	74	..	..	93	59	100(92)	65	75
	1980	"	50	..	80	30	10	90	30	100	50	25
Population With Access to Safe Water	1993	%	79	42	78	32	45	60	77	..	34	70(92)
	1980	"	55	32	41	27	15	37	66	..	..	24
	1970	"	31	11	56	17	8	..	..	..	.	..
Population With Access to Sanitation	1993	%	16	55	35	40	6	61	87	..	13	..
	1980	"	7	23	3	20	..	..	..	..	..	..
Central Government Expenditure on Health*	1993	% Tot. Exp.	1.9	2.7	5.9	7.4	4.7	5.2	8.2	..	4.8	9.7(90)
	1980	"	1.6	2.5	4.3	5.3	3.9	4.9	4.1	..	5.1(85)	3.5
	1975	"	2.4	2.0	5.4	6.6	5.9	6.1	3.7			

Note: The figures given are not fully comparable as they are from different sources, and different periods of reference due to non availability.

Source: World Dev. Report 1995 & 1996 - World Bank.. Not Available
Human Dev. Report 1994 & 1995 - UN
Economic & Social Survey of Asia & Pacific 1996 - UN
World Tables 1980 & 1994 - World Bank
Social Indicators of Development 1994 - World Bank
Enhancement of Social Security for the poor - Marga Institute

Table 1.3
Indicators of Education in SEAR Countries

Indicators	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
Enrollment in Primary Education	1992	% of age group	102	115	77	105	102	107	97	104	25	..
	1980	"	83	107	62	91	88	103	99	..	27	..
	1970	"	73	80	54	83	26	99	83	..	6	..
Enrollment in Secondary Education	1992	"	44	38	19	20	36	74	33	..	5	..
	1980	"	32	29	18	23	22	55	29	..	4	..
	1970	"	26	16	19	21	10	47	17	..	1	..
Pupil/Teacher ratio	1992	"	63	23	63	..	39	29	17	..	..	..
	1970	"	41	.	46	47	..	..	35	..	..	.
Adult Literacy rate*	1992	"	50	82	36	82	26	89	93	..	39	93
	1980	"	36(77)	62(78)	26(77)	66	19	85(79)	86	..	32	..
	1970	"	34	57	23	60(60)	14	78	79	..	..	..
Central Govt.* Expenditure on Education	1993	% of Total Exp.	2.2	10.0	10.8	17.0	10.9	10.4	21.1	..	10.7	11.3(90)
	1980	"	1.9	8.3	6.6	10.6	9.9	6.7	19.8	..	9.6(85)	4.7
	1975	"	2.3	8.9	11.9	13.5	10.3	10.5	20.1	..	..	..

Note: The figures given are not fully comparable as they are from different sources, and different periods of reference due to non availability.

.. Not Available

Source: World Dev. Report 1995 & 1996 - World Bank
Human Dev. Report 1994 & 1995 - UN
World Tables 1980 & 1994 - World Bank
Social Indication of Development 1994 - World Bank
Economic & Social Survey of Asia & Pacific 1996 - UN

Table 1.4
Indicators of Income and Income Distribution in SEAR Countries

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
GNP Per Capita	1993	US $	310	670	220	100(92)	190	600	2110	..	180(92)	500(92)
	1980	"	290	550	150	200(87)	140	270	670	1240(88)	130	290
	1970	"	160	210	130	..	110	..	..	.	..	120
Purchasing Parity Power per capita	1991	US $	1150	2730	1160	..	1130	2650	5270	3026(92)	620	.
	1987	"	1050	1660	880	750	720	2050	2580	..	.	..
Annual Average Growth Rate of GNP Per capita	1985-94	%	2.9	6.0	2.0	..	2.3	2.9	8.6	.	.	.
	1965-83	"	1.5	5.0	0.5	..	0.1	2.9	4.3	.	.	.
People in Absolute Poverty	1990	%	31[1]	17	52	..	40.0	22[1]	19[1]	.	.	.
	1980-90	"	40	25.0	78	35	60	39	30	..	..	.
Income Ratio of Highest 20% to Lowest 20% Households	1992	%	4.7	4.9	4.1	..	4.3	4.4	8.3	..	.	..
Income Share of Lowest 40% Households	1992	%	21.3	20.8	22.9	..	22.0	22.0	15.5	.	.	.

Source: World Development Report 1982, 1995, 1996 - World Bank
Human Development Report 1990, 1994, 1995, 1996 - UN
Enhancement of Social Security of the poor Marga Institute

[1] From most recent Country Reports .. Not Available

Table 1.5
Human Development Indicators in SEAR Countries

Index/Indicator	Year	Range/Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
Human Development Index	1993	0-1	0.436	0.641	0.365	0.451	0.332	0.698	0.832	0.714	0.307	0.610
Gender Development Index	1993	0-1	0.410	0.616	0.336	0.447	0.308	0.679	0.811	..	.	0.599
Gender Empowerment Index		0-1	0.235	0.367	0.291	..	..	0.306	0.390	.	..	0.324
Capability Poverty Index	1993	0-1	0.615	0.423	0.769	0.344	0.773	0.193	0.211	..	0.682	0.355
Real GDP Per Capita (PPP)	1993	US $	1240	3270	1290	650(92)	1000	3030	8360		..	.
	1960	US $	617	490	621	341	584	1389	1783	..	..	..

.. Not Available

Source: Human Development Report-1996

Annex B

Table 2.
Economic Indicators of SEAR Countries

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
GDP Average Annual Growth Rate	1970-80	%	3.4	7.2	2.3	4.7	2.0	4.1	7.1	..	..	9.8(85-90)
	1980-90	"	5.8	6.1	4.3	0.6	4.6	4.2	7.6	..	..	..
	1990-94	"	3.8	7.6	4.2	5.7	4.9	5.4	8.2	..	..	..
G.N.P. Per capita Average Annual Growth Rate	1965-83	%	1.5	5.0	0.5	..	0.1	2.9	4.3	..	..	..
	1985-94	"	2.9	6.0	2.0	..	2.3	2.9	8.6	..	..	..
Gross Domestic Investment	1971-80	Average	20.5	19.3	9.1	13.9	16.3	19.0	25.3	..	..	..
	1981-90	"	22.6	30.4	13.2	15.3	19.4	24.7	30.6	..	35.5	..
	1991	% of GDP	23.6	35.5	11.5	15.3	22.7	22.6	42.2	..	23.6	28.2(90)
	1992	"	22.0	35.9	12.3	13.6	22.7	23.9	39.6	..	43.4	42.8
	1993	"	20.4	35.3	13.6	12.1	21.4	25.3	40.0	..	28.2	34.0
	1994	"	23	29	14	12	21	27	40	..	38(81-90)	34(93)
Gross Domestic Savings'	1971-80	Average	20.1	21.6	2.4	12.3	11.8	13.2	22.2	..	..	..
	1981-90	"	20.8	31.8	2.1	12.0	10.4	14.4	27.2	..	10.1	..
	1970	% of GDP	16.0	14.0	7.0	11.0	3.0	16.0	21.0	..	..	..
	1991	"	23.1	35.9	4.1	14.0	9.6	13.7	35.8	..	6.5	..
	1992	"	20.0	38.2	5.8	12.8	10.8	16.4	35.7	..	7.5	..
	1993	"	20.2	37.7	6.5	11.1	11.7	17.7	35.5	..	8.7	..
Average Annual Rate of Inflation	1970-80	%	8.4	21.5	20.8	11.4	8.5	12.3	9.2	..	..	..
	1980-93	"	8.7	8.5	8.6	16.5	11.5	11.1	4.3	..	9.2(81-90)	..
	1984-94	"	9.7	8.9	6.6	26.5	12.1	11.0	5.0	..	..	..

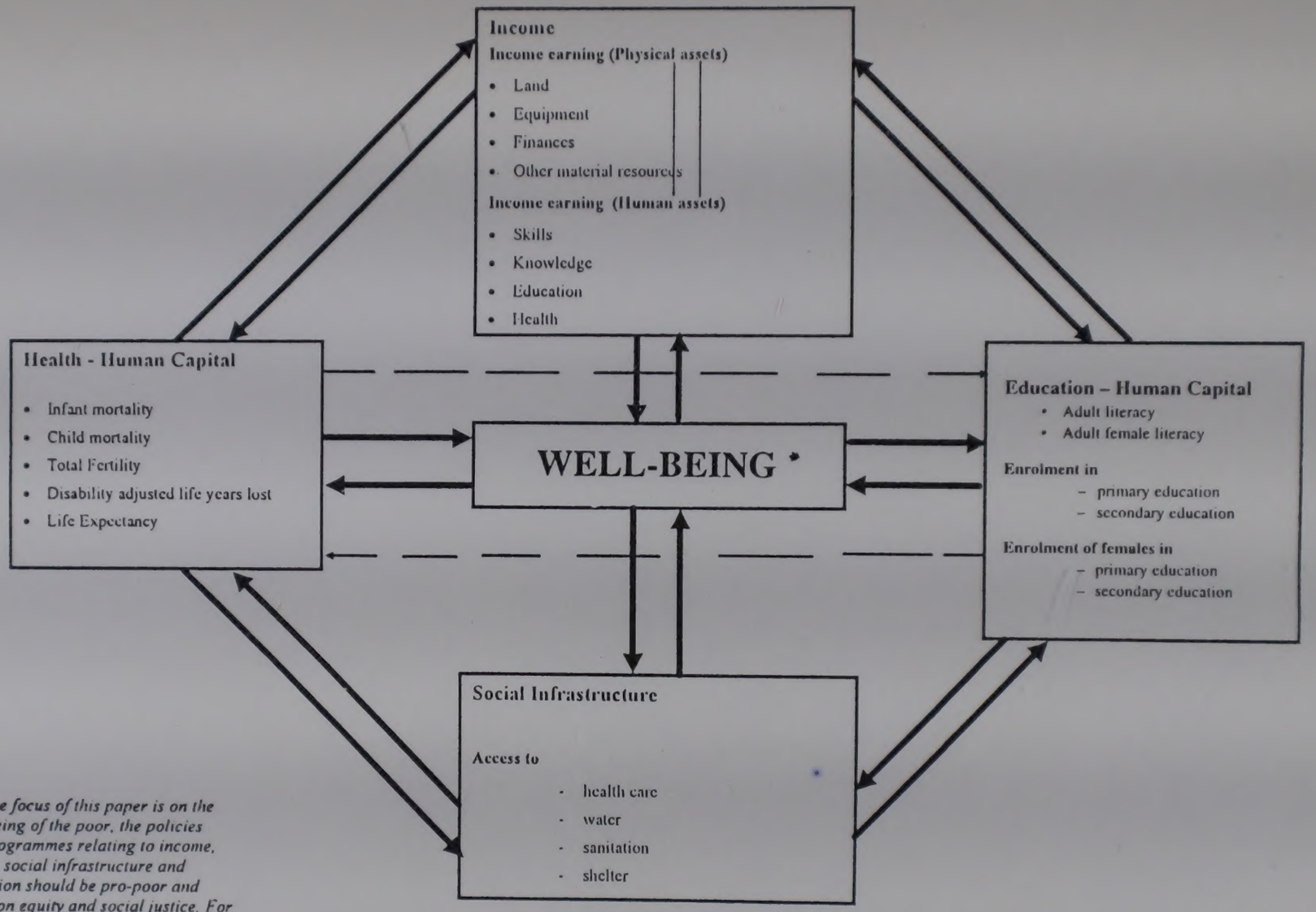
Contd...

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	DPR Korea	Bhutan	Maldives
Balance of Payments on Current Account	1986	% of GDP	-2.0	-4.9	-4.1	-3.6	-5.0	-6.5	0.6	..	-42.9	-10.8(85)
	1989	"	-2.1	-1.2	-5.4	-0.4	-7.4	-5.8	-3.5	..	-18.0	8.3
	1991	"	-0.1	-3.7	0.3	-1.1	-9.4	-6.5	-7.7	..	-4.7	-5.5
	1992	"	-1.1	-2.2	0.8	-0.7	-6.5	-4.6	-5.7	..	-7.5	-10.3
	1993	"	0.2	-1.4	0.8	-0.5	-6.0	-3.6	-5.5	..	-24.7	-21.9
Debt Service Ratio	1986	%	32.0	38.7	29.3	80.6	9.2	20.9	30.1	..	..	..
	1989	"	28.3	35.4	20.3	43.4	15.5	18.6	16.3	..	5.6	..
	1991	"	30.6	32.0	20.3	11.3	13.8	13.9	13.0	..	6.7	..
	1992	"	29.4	30.6	16.0	7.0	11.5	13.1	14.1	..	6.3	..
	1993	"	28.4	32.6	13.5	..	8.5	9.9	18.6	..	17.4	..
Government Expenditure	1986	% of GDP	17.6	21.3	15.2	13.4	19.4	31.9	18.6	..	43.6	..
	1989	"	20.3	18.6	16.8	12.6	20.2	30.3	14.2	..	47.7	54.3
	1990	"	19.7	18.7	17.1	14.2	19.0	28.0	13.9	..	37.3	52.6
	1991	"	18.1	19.3	16.4	13.5	19.6	29.0	14.4	..	32.6	62.6
	1992	"	17.4	19.1	15.9	10.9	17.7	26.5	15.6	..	34.5	59.5
Overall Government Expenditure Surplus/Deficit	1980	% GNP	-6.5	-2.3	2.5	1.2	-3.0	-18.4	-4.9	..	..	..
	1993	"	-4.8	0.7	..	-3.1	-6.3	-6.4	2.1	..	..	..

.. Not Available

Source: Asian Development Outlook 1992, 1995/96 Issues ADB
Trends in Developing Economies 1995 - World Bank
World Development Report 1985, 1995, 1996 - World Bank

THE PROCESS OF INTERACTION IN ACHIEVING WELL-BEING



** As the focus of this paper is on the well-being of the poor, the policies and programmes relating to income, health, social infrastructure and education should be pro-poor and based on equity and social justice. For example, the social infrastructure and income-earning human assets should be made accessible to the poor.*